

Arise Chiropractic Wellness Center, LLC  
Dr. Lisa M. Hinkle  
605 N. Bentz Street, Suite 103 \* Frederick, MD 21701  
Phone (301) 662-4220 \* Fax (301) 662-8195

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## PEDIATRIC INTAKE FORM

### Personal Information

Full Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parents' Names: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Parent Email Address: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Siblings Names: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

How did you hear about our center? \_\_\_\_\_

### Purpose of Care

Please answer all questions on behalf of your child if they are not old enough to fill out this form on their own.

What is/are the health condition(s) you are concerned with today?

\*Major concern? \_\_\_\_\_

\*Onset? \_\_\_\_\_

Is this condition (please circle): getting worse constant comes and goes

Is this condition interfering with your (please circle): school sleep daily routine.

Have you had this or similar conditions in the past? \_\_\_\_\_

Have you been treated by a medical doctor for this condition? \_\_\_\_\_

If so, where? \_\_\_\_\_ Results? \_\_\_\_\_

Have you ever had Chiropractic Care before? \_\_\_\_\_

If so, whom? \_\_\_\_\_ Results? \_\_\_\_\_

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**Health History:**

Please explain any difficulties during pregnancy or labor: \_\_\_\_\_

The following occurred at delivery (please circle all that apply):

Vaginal Delivery	Planned C-Section	Emergency C-Section
Face Presentation	Forceps/Vacuum	Induced labor/Pitocin
Breech Presentation	Anesthesia Used	Neonatal Intensive care

During Infancy my child was: Breast Fed \_\_\_\_\_ months    Bottle Fed \_\_\_\_\_ months

My child is on the following vaccine schedule (please circle):    standard    alternative    none

**PERSONAL HEALTH HISTORY - Has this child ever suffered from:**

Major falls/injuries/fractures	Respiratory problems	Ear Infection
Allergy/Asthma	Bedwetting	Digestive problems
Hyperactivity	Hospitalization	Extremity pain
Anxiety Disorders	Seizures	Back pain
Recurrent antibiotic use	Behavioral problems	Poor appetite
Dizziness/Fainting	Heart trouble	Diabetes
Anemia/Blood Disorders	Tuberculosis	High blood pressure
Arthritis	Headaches	Growing Pains
Colic	Sinus trouble	

My child has met all developmental milestones: Yes / No

Please list any other serious medical condition(s): \_\_\_\_\_

Allergies to foods or medications: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Past Serious Accidents: \_\_\_\_\_

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**Please answer the following as completely as possible. Does your child:**

Take supplements or vitamins? \_\_\_\_\_

Take Prescription Drugs? Please list: \_\_\_\_\_

Follow a special diet? \_\_\_\_\_

Carry a backpack (what style)? \_\_\_\_\_

Play Sports (which one(s))? \_\_\_\_\_

Watch TV (amount/day)? \_\_\_\_\_

Play Computer/Video Games (amt/day)? \_\_\_\_\_

**FAMILY HEALTH HISTORY - Please circle the conditions below if someone in the child's immediate family has had the following. Please write how they are related to the child.**

Back Problems _____	Headaches _____
High blood pressure _____	Ulcer/Digestive Problem _____
Thyroid Disorder _____	Heart Disease _____
Stroke _____	Arthritis _____
Diabetes _____	Cancer _____
Osteoporosis _____	Mental Illness _____

**Wellness Profile:**

**Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for this child. Circle as many goals as you wish.**

more energy	better sleep	freedom from pain
easier breathing	more balanced posture	improve nutrition
improved coordination	reduce medications	improve overall health
better sports performance	enhanced emotional well-being	better concentration
greater resistance to disease	relief care for current symptoms	other _____

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**OFFICE POLICIES**

**Office Payment Policies**

I agree to take full responsibility for my child's care in the event that the assumed insurance coverage, including worker's compensation, no fault insurance, personal injury insurance, etc is denied.

I further understand that I will be charged a \$30 missed appointment fee for appointments that are missed or canceled without 24 hours notice prior to the scheduled appointment time.

**Patient/Legal Guardian's Initials:** \_\_\_\_\_

**Notice of Patient Privacy Practices: HIPAA**

By signing below, I acknowledge that I have had the opportunity to review a copy of the Patient Privacy Practices of Arise Chiropractic Wellness Center, LLC, and a copy will be available for me at any time upon my request.

The Health Insurance Portability and Accountability Act ensures a patient's right to privacy regarding personal health information and it is this office's policy to maintain confidentiality to the highest degree.

**Patient/Legal Guardian's Initials:** \_\_\_\_\_

**Consent to Treat a Minor**

I hereby authorize Arise Chiropractic Wellness Center, LLC and its doctors to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date